

ORIGINAL RESEARCH

The relationship between therapist experiential avoidance and observed CBT competence during training: a preliminary investigation

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Abstract

The psychological literature highlights experiential avoidance as a transdiagnostic maintenance factor for a number of psychopathologies. Some attention has been given to therapist experiential avoidance, with the suggestion that this interferes with the acquisition and execution of CBT skills; there is, however, a paucity of research directly examining this relationship. This study aimed to measure experiential avoidance in trainee cognitive behavioural therapists, and establish any relationships with observed clinical competence. Twenty-nine trainee therapists took part in the study; levels of experiential avoidance were measured using the Multidimensional Experiential Avoidance Questionnaire and were analysed in relation to observed CBT skills assessed using the Cognitive Therapy Scale (Revised). No overall relationship between therapist experiential avoidance and clinical competency was observed. However, a number of significant associations were observed between individual dimensions of therapist experiential avoidance and CBT skills in collaboration, guided discovery, conceptual integration and homework setting. Aspects of therapist experiential avoidance during training may therefore be associated with the acquisition of key CBT skills. Tentative interpretations and recommendations for CBT training and supervision have been made, although further investigation is required.

Key learning aims

- (1) To understand the role of experiential avoidance in psychopathology.
- (2) To understand the relevance of *client* experiential avoidance as part of CBT treatment.
- (3) To examine the potential impact of *therapist* experiential avoidance on the development and execution of key CBT skills.
- (4) To consider implications for CBT training, supervision and clinical practice.

Keywords: CBT training; Experiential avoidance; Therapist schema

Introduction

Experiential avoidance and its importance in psychopathology

Experiential avoidance refers to the phenomenon that occurs when an individual is unwilling to remain in contact with uncomfortable internal experiences such as thoughts, memories, emotions, physiological sensations and behavioural dispositions (Hayes *et al.*, 1996). Experiential avoidance may be actively achieved via any number of unhelpful cognitive (e.g. suppression) or behavioural (e.g. procrastination) strategies, with the suggestion that experiential avoidance mediates the

relationships between maladaptive coping responses and psychological distress (Chawla and Ostafin, 2007). For example, it has been reported that suppressing emotions not only leads to increased physiological arousal, but also does not provide relief from the subjective experience of that emotion (Gross and Levenson, 1997). Suppressing emotions may also result in cognitive impairment, unhelpful behaviours and interpersonal difficulties (Gross and Levenson, 1997), as well as contribute to increased anxiety, psychosomatic complaints and difficulties with substance use (Power, 2010).

Indeed, experiential avoidance has been reported over recent years to be a transdiagnostic maintenance factor across a range of psychological disorders (Chawla and Ostafin, 2007; Michel *et al.*, 2016). Difficulties with tolerating distress have been shown to be correlated with generalised anxiety disorder (GAD; Macatee *et al.*, 2015) as well as depressive and worry symptoms (Macatee *et al.*, 2016). Similarly, a greater capacity for tolerating distress has been found to be negatively associated with anxiety sensitivity and intolerance of uncertainty, and therefore with GAD, social anxiety disorder (SAD) and obsessive-compulsive disorder (OCD; Laposa *et al.*, 2015). Maladaptive attempts to avoid or suppress distressing emotions can lead to an increased experience of those emotions, resulting in a maintenance cycle which prevents helpful emotional processing or habituation (Barlow, 2011). Similarly, the acceptance of negative emotional experiences has been indicated as a potential protective factor against the development of depressive symptoms (Shallcross *et al.*, 2010). Overall, emotional acceptance and expression have been linked to better coping and decreased distress even during times of adversity (Stanton *et al.*, 2000). In line with this, Macatee *et al.* (2016) found that clients with depression and anxiety may benefit from interventions designed to improve distress intolerance.

The significance of experiential avoidance in CBT

A central tenet of cognitive behavioural treatment is to help the client reappraise unhelpful thoughts and behaviours that serve to maintain their psychological difficulties (Beck, 1989). Whilst the cognitive-behavioural approach is widely supported by the evidence base across different psychopathologies, research tends to lack investigation into the effectiveness of specific cognitive-behavioural strategies (Bennett-Levy *et al.*, 2004). Despite this, there is emerging evidence that those interventions that lack an experiential component are less effective than those that do (Bennett-Levy, 2003). For example, belief change has been found to be more effective when utilising behavioural experiments (i.e. testing a belief via active experimentation) as opposed to utilising verbal or written evaluation methods only (Bennett-Levy, 2003; McManus *et al.*, 2011). One explanation for these findings is that interventions which incorporate an experiential component (and therefore emotional activation) allow the client to process information at a deeper 'implicational' level (Teasdale, 1997), rather than at an intellectual or rational level which may be less effective in facilitating change (Bennett-Levy *et al.*, 2004). Essentially, cognitive-behavioural intervention should aim for a unification of 'head and heart', whereby the client not only *knows* an alternative perspective, but also *believes* it – a process achieved via experiential learning. Therefore, whilst CBT is not primarily conceptualised as functioning via emotional processes *per se*, there is growing evidence that emotional processing is fundamental to psychological change and recovery (Baker *et al.*, 2012). This is supported by research demonstrating the efficacy of Barlow *et al.*'s (2011) Unified Protocol (UP) (Carlucci *et al.*, 2021), an emotion-focused cognitive-behavioural treatment which focuses on reducing emotional avoidance and facilitating appropriate emotional processing (Wilamowska *et al.*, 2010). Concordantly, reduced experiential avoidance has been shown to be significantly associated with reductions in anxiety as a function of CBT treatment (Eustis *et al.*, 2019), although less so than third-wave approaches such as acceptance and commitment therapy (ACT) which target this directly (Arch *et al.*, 2012; Niles *et al.*, 2014). Implicitly, it may therefore be inferred that those

clients presenting for CBT treatment who have difficulties with experiential avoidance are at risk of reduced benefit should this not be addressed as part of treatment.

What about therapist experiential avoidance?

Whilst there has been some investigation into the role of client experiential avoidance in maintaining psychological difficulties, until more recently there has been less focus on therapist experiential avoidance and how this might impede psychological treatments. Some authors suggest that in the same way that client beliefs about emotions can be problematic, *therapist* beliefs about emotions can also be detrimental to the therapy process (Leahy, 2016). The importance of therapists identifying their own schema and reflecting upon the potential impact on their therapeutic work with clients has been variously documented in the CBT literature (Haarhoff, 2006; Leahy, 2001; Presley *et al.*, 2017; Young *et al.*, 2003). Accordingly, the implementation of self-practice and self-reflection (SP/SR) has been more strongly advocated, with the experiential element of this shown to be particularly useful during CBT training (Bennet-Levy *et al.*, 2001; Bennet-Levy *et al.*, 2003). For example, research suggests that engagement in SP/SR can improve the technical aspects of therapy such as CBT formulation skills (Haarhoff *et al.*, 2011) as well as interpersonal effectiveness (Bennett-Levy and Thwaites, 2007).

Indeed, experiential learning is a fundamental component of adult learning theory (Kolb, 1984) which is integral to CBT training. This theory suggests that personal development is achieved via a four-stage process which includes active experimentation and felt experience, as well as more passive observational and conceptual modes of learning. The Declarative-Procedural-Reflective (DPR) model developed by Bennett-Levy (2006) focuses on understanding therapist skills development specifically, with evidence that experiential learning is key to developing the 'procedural' or 'professional artistry' skills in particular (Bennett-Levy *et al.*, 2009; p. 573). In line with these theoretical conceptualisations, authors have suggested that therapist experiential avoidance is detrimental to their learning experience in training. For example, Lombardo *et al.* (2009) suggested that therapist emotions are important in the process of learning and its transfer to practice, whilst Milne and Reiser (2017) highlighted that supervision should include the same experiential methods that are fundamental to effective CBT treatment. It is noted that trainee therapists will likely experience anxiety as part of the training experience, for example due to feeling deskilled or having concerns about making mistakes with clients, but that these anxieties should be resolved via experiential learning strategies (Reiser and Milne, 2013) rather than collusion or avoidance (Milne *et al.*, 2009). Therapist experiential avoidance may therefore impede the learning process during training (for example by avoiding active learning opportunities such as role-rehearsal or direct observation of skills), in the same way that client experiential avoidance may impede their progress in therapy.

In addition to undermining the learning experience during training, therapists' desire to avoid personal discomfort has been suggested as a contributing factor in poorer execution of key CBT skills such as homework setting (Haarhoff and Kazantzis, 2007), as well as resulting in the avoidance of behavioural change strategies (Meyer *et al.*, 2014) and the selection and implementation of evidence-based interventions such as imagery (Bell *et al.*, 2015), and exposure therapy in OCD (Scherr *et al.*, 2015), even beyond training. It has been proposed that CBT requires both the therapist and the client to tolerate a degree of uncertainty as part of the treatment process; therapists unable to do so may engage in safety behaviours which reduce their own anxiety, but also inadvertently impede their competence (Waller and Turner, 2016). Moreover, Leahy (2015) suggested that unhelpful therapist beliefs about emotions may result in problematic approaches to therapy such as over-emphasising rationality and implying that painful emotions are problematic. This may be accompanied by a didactic and lecturing interpersonal style contrary to effective guided discovery (Padesky, 1993), with inadequate session pacing to allow for emotional exploration (Leahy, 2015). This is supported by research

demonstrating that therapist interactions laden with a high frequency of cognitive speech were found to be negatively related to emotional processing and treatment outcome (Anderson *et al.*, 1999). Interestingly, research to elucidate the frequency of therapists expressing their emotions by crying in therapy (TCIT) found that cognitive-behavioural therapists were significantly lower in TCIT tendency than all other therapeutic modalities investigated (Blume-Marcovici *et al.*, 2013). Indeed, a noted limitation of CBT more generally is the propensity for intellectualising emotional experiences and favouring an educational approach rather than one that allows exploration of affect (Mackay *et al.*, 2002); unhelpful beliefs about emotions resulting in therapist experiential avoidance may compound this notion as part of CBT training and beyond.

In summary, there are a number of assertions in the CBT literature which suggest that therapist experiential avoidance may impede learning opportunities during CBT training, and result in unhelpful approaches to CBT practice. It may therefore be that both of these factors impact upon therapist effectiveness across a number of key CBT competences. Despite this, there is a paucity of empirical research that directly examines the relationship between aspects of trainee therapist experiential avoidance and developing clinical competence in CBT skills. The aims of this preliminary study were therefore twofold:

- (1) To estimate the incidence of experiential avoidance amongst a sample of trainee CBT therapists;
- (2) To test the following hypotheses:
 - (a) Therapist experiential avoidance is associated with overall observed clinical competence during CBT training;
 - (b) Cognitive and behavioural aspects of therapist experiential avoidance are associated with observed clinical competence in specific CBT skills during training.

Method

Design

A cross-sectional design was used for this study.

Participants

A convenience sample of 29 trainee CBT therapists were recruited across two training cohorts enrolled on the Postgraduate Diploma in Cognitive Behavioural Therapy at the authors' employing university. Fifty-five trainees were invited to take part, with 30 agreeing to do so. One participant's data were removed due to missing data. Of the 29 remaining participants, three were male (mean age 47.7 years; $SD = 7.64$) and 26 were female (mean age 35.7 years; $SD = 9.88$). The trainees had entered training from varying professional backgrounds. Nine had a British Association for Behavioural and Cognitive Psychotherapies (BABCP)-approved core profession; this included two BABCP-accredited counsellors and seven Registered Mental Health Nurses. The remaining 20 participants met the BABCP 'Knowledge, Skills and Attitudes' (KSA) criteria instead; of these 20 trainees, 14 had previously completed low-intensity CBT 'Psychological Wellbeing Practitioner' (PWP) training.

Measures

Multidimensional Experiential Avoidance Questionnaire (MEAQ)

Trainee therapist experiential avoidance was measured using the MEAQ (Gámez *et al.*, 2011). The MEAQ is a 62-item self-report measure of experiential avoidance consisting of six individual subscales: 'Behavioural Avoidance', 'Distress Aversion', 'Procrastination', 'Distraction and Suppression', 'Repression and Denial', and 'Distress Endurance' (Gámez *et al.*, 2011). Example

Table 1. Example MEAQ questionnaire items

MEAQ subscale	Example questionnaire item
Behavioural Avoidance	I won't do something if I think it will make me uncomfortable
Distress Aversion	When I am hurting, I would do anything to feel better
Procrastination	I try to put off unpleasant tasks for as long as possible
Distraction and Suppression	When something unpleasant comes up, I try very hard to stop thinking about it
Repression and Denial	I am able to 'turn off' my emotions when I don't want to feel
Distress Endurance	People should face their fears

questionnaire items for each subscale are listed in Table 1. Each item is scored using a Likert scale from '1' (strongly disagree) to '6' (strongly agree). The MEAQ demonstrates excellent internal consistency (Cronbach's $\alpha = .92$; Gámez *et al.*, 2011), and was selected in order to highlight how different aspects of trainee experiential avoidance may interact with specific areas of observed clinical competence. The measure includes an inverse subscale ('Distress Endurance'), therefore further allowing exploration of the impact of distress tolerance on aspects of clinical competency.

Cognitive Therapy Scale-Revised (CTSR)

CBT competence was measured using the CTSR (James *et al.*, 2001). The CTSR is a 12-item scale measuring therapist competence in CBT, focusing on a range of specific therapeutic skills. These include implementing an appropriate CBT session structure (setting an agenda, effective session pacing, setting a homework task) and adherence to the CBT model (eliciting pertinent thoughts, emotions and behaviours, integrating a CBT conceptualisation, applying a CBT change method). The measure also assesses ways of relating to the client in the session (interpersonal effectiveness, collaboration, use of two-way feedback, using guided discovery as opposed to didactic instruction). A detailed explanation of the 12 CTSR criteria and descriptors of clinical skill can be found in the CTSR manual (James *et al.*, 2001). CTSR items are carefully defined for markers and rated on a 7-point competency scale. This unipolar Likert scale extends from 'incompetent' (level 0) to 'expert' (level 6). The CTSR demonstrates excellent internal consistency, with Cronbach's α between four raters ranging between $\alpha = .92$ and $\alpha = .97$ (Blackburn *et al.*, 2001) and is widely utilised on CBT training programmes as a formal means of assessing trainee clinical competence.

Procedure

Ethical approval for the research was granted by the authors' University Research Ethics Committee. Trainee CBT therapists enrolled on the PgD in CBT across two consecutive cohorts were informed about the research via lecture attendance and their online learning environment, and invited to contact the research team should they be interested in taking part.

All data were collected during the final semester of the training programme. Participating trainees completed the MEAQ questionnaire which was anonymised using a unique participant ID number by a member of the research team external to the CBT teaching team (M.M.). This was intended to decrease any social desirability bias in questionnaire answers that may be otherwise present. CTSR scores were obtained from a final summative assessment of clinical session recordings, and marked by members of the CBT teaching team. All markers in the team were BABCP-accredited practitioners and had completed an annual CTSR calibration exercise in efforts to standardise marking and scores awarded. Furthermore, the assessment was subject to the standard university internal and external moderation processes. Using these CTSR assessments was intended to (a) reduce any additional burden on participants of the research project, (b) ensure consistency between markers and therefore scores awarded across CTSR items, and

(c) provide an indication of any association between trainee experiential avoidance and end-of-training therapeutic competence. Again, CTSR assessment scores were anonymised using the relevant participant ID number by M.M., and then paired with the associated MEAQ scores for each participating trainee.

Data analysis

Incidence of experiential avoidance

Descriptive statistics were obtained to investigate the range of MEAQ scores in the sample. The proportion of trainee therapists within the sample group exhibiting high levels of experiential avoidance was then estimated by calculating the percentage of trainees who scored one standard deviation (*SD*) above the mean on the MEAQ (and its subscales) as defined by the published normative data for the measure (Gámez *et al.*, 2011). Below average scores were defined as those one *SD* below the mean; average scores were those within one *SD* either side of the mean.

Experiential avoidance and observed clinical competence

In order to investigate any relationship between therapist experiential avoidance and observed clinical competence during training, the data were analysed in a number of phases. Firstly, as with the MEAQ scores, descriptive statistics were obtained to understand the range of CTSR scores in the sample. The data were also inspected to establish the number of trainees that reached overall clinical competence (defined as an overall score of 36 or above, with scores of 2 or above on individual items) according to the CTSR assessment. Secondly, Pearson's correlation coefficients were calculated in order to provide an overview of any potential relationships between total MEAQ scores and total CTSR scores, and between individual MEAQ subscales and the 12 individual CTSR items. Finally, regression analyses were performed in two phases in line with the initial hypotheses: (1) a simple linear regression was conducted to assess the contribution of emotional avoidance as measured by total MEAQ scores to overall clinical competence as measured by total CTSR Scores; and (2) backward elimination ordinary least squares regression analyses were undertaken to allow more detailed assessment of the contribution of dimensions of emotional avoidance as measured by the six MEAQ subscales to clinical competence on each of the 12 CTSR items.

Results

Estimated incidence of experiential avoidance amongst trainee therapists

Descriptive statistics for the MEAQ can be found in Table 2; normative data for the measure are included here for comparison, indicating that the sample means for overall and subscale scores are equivalent or lower. Concordantly, the proportion of therapists scoring in problematic ranges across the MEAQ was low, with most appearing to score within the average range (see Table 3). The proportion of therapists scoring in the above-average ranges was highest for the MEAQ subscales 'Procrastination' (14%) and 'Distress Endurance' (24%). Upon closer inspection of the data, it was also noted that over one-third of trainees scored above the normative means in terms of total MEAQ score (34%), and the 'Procrastination' (62%), 'Repression and Denial' (34%) and 'Distress Endurance' (52%) subscales.

Is trainee therapist experiential avoidance associated with observed CBT competence during training?

Descriptive statistics

The sample mean for overall CTSR scores was 42.8 (*SD* = 1.15). Descriptive statistics for the 12 individual CTSR items are presented in Table 4. On average, trainee therapist skills were rated

Table 2. Mean and standard deviation scores for the MEAQ

	MEAQ subscale/total						
	MEAQ BA	MEAQ DA	MEAQ P	MEAQ DS	MEAQ RD	MEAQ DE	MEAQ total
Sample mean	29.45	34.76	22.41	22.52	29.00	49.72	165.41
Sample SD	1.83	2.14	1.38	1.17	1.57	1.38	6.56
Normative mean	34.40	41.65	22.41	25.64	31.31	47.12	185.29
Normative SD	10.41	11.97	7.45	6.58	10.77	7.93	39.95

Subscales: BA, Behavioural Avoidance; DA, Distress Aversion; P, Procrastination; DS, Distraction and Suppression; RD, Repression and Denial; DE, Distress Endurance.

Table 3. Summary of trainee therapist MEAQ scores

Measurement	Proportion of therapists with a score < average	Proportion of therapists with an average score	Proportion of therapists with a score > average	Proportion of therapists with a score > normative mean
MEAQ Total Score	34%	66%	0%	34%
MEAQ Behavioural Avoidance	24%	72%	4%	31%
MEAQ Distress Aversion	34%	62%	4%	24%
MEAQ Procrastination	17%	69%	14%	62%
MEAQ Distraction and Suppression	34%	59%	7%	28%
MEAQ Repression and Denial	20%	76%	4%	34%
MEAQ Distress Endurance	7%	69%	24%	52%

highest for interpersonal skills, and lowest for eliciting emotions. Only one trainee in the sample failed their CTSR assessment with a score below the pass threshold of 36; this trainee had a high MEAQ score, but one which fell just inside the normal range according to published normative data for the measure.

Exploratory analysis

A correlation matrix of all study variables, constructed for exploratory purposes, indicated which MEAQ subscales had a higher likelihood of being related to individual CTSR scores; total scores for both measures were also included in this analysis. These relationships are illustrated in Table 5, with 'Procrastination' and 'Repression and Denial' yielding the strongest associations with individual CTSR items.

Regression analyses

Linear regression analysis indicated a non-significant negative relationship between total MEAQ scores and total CTSR scores ($R^2 = 0.018$, $F_{1,27} = 0.484$, $p > 0.05$).

Backward elimination regression analyses revealed a number of significant negative relationships between the MEAQ subscales and each of the individual items on the CTSR as the dependent variable. The standardised and unstandardised beta coefficients, confidence intervals, t values and associated significant levels are reported in Table 6 for the final regression model for each CTSR item, illustrating the significant relationships observed (CTSR items that had no significant predictors left in the final model are not included in this table). A Pearson's correlation matrix for the subscales of the MEAQ demonstrated no significant collinearity between the facets of emotional avoidance measured. Additionally, variance inflation factor (VIF) values were all in an acceptable range, supporting the absence of problematic multicollinearity

Table 4. Mean and standard deviation for trainee scores on the CTSR

	CTSR item												Total CTSR score
	Agenda Setting	Feedback	Collaboration	Pacing	Interpersonal Skills	Eliciting Emotions	Eliciting Cognitions	Planning Behaviours	Guided Discovery	Conceptual Integration	Change Methods	Homework	
Mean score	3.59	3.67	3.72	3.5	4.12	3.17	3.48	3.59	3.5	3.31	3.69	3.47	42.78
SD	0.15	0.12	0.16	0.16	0.12	0.13	0.14	0.16	0.13	0.13	0.19	0.16	1.15

Table 5. Correlation matrix illustrating relationships between MEAQ and CTSR scores

CTSR item/score	MEAQ subscale/score							MEAQ total score
	Behavioural Avoidance	Distress Aversion	Procrastination	Distraction and Suppression	Repression and Denial	Distress Endurance		
Agenda Setting	-.072	.034	-.110	.123	-.096	-.038	-.025	
Feedback	.038	.261	.085	-.036	-.118	-.076	.095	
Collaboration	-.010	-.066	-.059	-.197	-.444*	-.045	-.168	
Pacing	-.006	-.041	-.236	-.213	-.340	.050	-.195	
Interpersonal	-.041	.039	-.065	-.062	-.108	-.174	-.013	
Emotions	-.108	.001	.127	-.179	-.158	-.139	-.044	
Cognitions	-.204	-.078	-.182	-.255	-.064	.056	-.193	
Behaviours	-.185	-.186	-.275	-.062	-.079	-.058	-.188	
Guided Discovery	.039	.129	-.061	-.168	-.377*	-.126	-.054	
Conceptual	.258	.144	.138	.265	-.286	-.362	.203	
Change Methods	-.088	-.012	-.261	-.134	-.133	-.151	-.108	
Homework	-.173	-.130	-.405*	-.250	-.323	-.124	-.271	
CTSR total score	-.078	.000	-.181	-.160	-.322	-.155	-.133	

Bold type denotes negative relationships. *Significant relationships ($p < 0.05$).

Table 6. Observed relationship data between MEAQ subscales and individual CTSR item scores

	MEAQ Procrastination	MEAQ Repression and Denial	MEAQ Distress Endurance	Model
Collaboration				
B (95% CI)		-0.046 (-0.083, -0.009)		$R^2 = 0.197$
β		-0.444		$F_{1,27} = 6.640$
t		-2.577		$p = 0.016$
p		0.016		
Guided Discovery				
B (95% CI)		-0.032 (-0.062, -0.001)		$R^2 = 0.142$
β		-0.377		$F_{1,27} = 4.480$
t		-2.117		$p = 0.044$
p		0.044		
Conceptual Integration				
B (95% CI)		-0.027 (-0.057, 0.004)	-0.037 (-0.072, -0.003)	$R^2 = 0.228$
β		-0.313	-0.383	$F_{2,26} = 3.845$
t		-1.811	-2.220	$p = 0.034$
p		0.082	0.035	
Homework Setting				
B (95% CI)	-0.066 (-0.110, -0.022)	-0.031 (-0.065, 0.004)	-0.047 (-0.091, -0.003)	$R^2 = 0.366$
β	-0.551	-0.293	-0.392	$F_{3,25} = 4.820$
t	-3.083	-1.833	-2.197	$p = 0.009$
p	0.005	0.079	0.037	

which may affect the analyses. Normality of the residuals was referenced using histograms and normality probability plots, with no serious issues with normality detected.

The MEAQ subscale 'Repression and Denial' yielded negative relationships with scores awarded across a number of CTSR items. Scores on this subscale of emotional avoidance were negatively associated with scores given by markers for CBT skills in 'Collaboration', 'Guided Discovery', 'Conceptual Integration' and 'Homework Setting'. However, p -values for both 'Conceptual Integration' and 'Homework Setting' were above the 0.05 significance level (0.082 and 0.079, respectively), despite the overall model being significant. This, along with confidence intervals that indicated positive values at the upper bound, suggested these negative relationships should be considered with caution. Visual inspection of scatter plots of these variables was therefore undertaken, supporting a weak relationship in both cases. 'Homework Setting' scores were more strongly negatively associated with MEAQ subscales scores for 'Procrastination', with this relationship being highly significant ($p < 0.01$). Finally, whilst most of the significant relationships observed in the data indicated a negative relationship between aspects of experiential avoidance and CBT skills, there was one MEAQ subscale exception to this. Scores for 'Distress Endurance' (an inverse subscale measuring a propensity for tolerating distress, rather than avoiding it) were negatively associated with CTSR scores for 'Conceptual Integration' and 'Homework Setting'.

Discussion

In this study, most trainee therapists scored within the average range on the MEAQ and its subscales, although over one-third scored above the normative means in terms of their overall MEAQ score and the 'Procrastination' and 'Repression and Denial' subscales. This indicated possible difficulties for these trainees with delaying tasks that might prompt emotional discomfort and with personal emotional awareness and connectedness. Conversely, over half of trainees scored above the normative mean for the 'Distress Endurance' subscale, indicating an ability to tolerate emotional discomfort and disallow difficult emotions from inhibiting their pursuit of important goals. Interestingly, all of these MEAQ subscales were *negatively* associated with aspects

of observed clinical practice. These initial findings provide some support for the notion that therapists may hold beliefs about emotions that are potentially unhelpful to the therapeutic process (Leahy, 2015), and engage in behaviours designed to avoid discomfort which may impede their learning experience during training. Of course, the MEAQ scores observed in this study may be biased by the self-selecting nature of the sample (experientially avoidant trainees may have opted not to take part) or by the self-report measures utilised (trainees may have answered in ways that they anticipated the research team would expect or approve of, and this was not assessed by use of a social desirability scale). Measures of experiential avoidance were also taken at only one time-point in this study; further research to establish whether trainee experiential avoidance and its association with therapeutic competence changes as a function of the training experience would be useful.

Contrary to the initial hypothesis, experiential avoidance as measured by total MEAQ scores was not significantly associated with overall clinical competence across the CTSR items. This suggested that trainee avoidance of emotional discomfort is not related to their overall development of clinical competency during training. However, upon more detailed analysis of the data, significant negative relationships were observed between specific cognitive and behavioural dimensions of trainee therapist experiential avoidance and particular aspects of their observed clinical competence during training. Trainee tendencies for emotional 'Repression and Denial' were negatively associated with observed skills in working collaboratively with the client during therapy. Effective collaboration requires the therapist to engage the client in an egalitarian process which facilitates a shared understanding of their difficulties, and a sense of teamwork in resolving them (James *et al.*, 2001). Although beyond the data of the current study to explain, it may be more difficult to tolerate the anxiety of relinquishing 'control' of the session in this way for those trainees with higher levels of experiential avoidance. This may be as a result of difficulties tolerating uncertainty as noted by Waller and Turner (2016); perhaps trainees attempt to avoid emotional arousal or discomfort by actively controlling session discussions and activities, rather than allowing the client to lead them into unknown territory.

Similarly, skills in using guided discovery were also shown to be negatively associated with the MEAQ subscale 'Repression and Denial'. The process of guided discovery requires the therapist to adopt an open and curious style which allows the client to develop new perspectives for themselves, without the use of didactic teaching (Padesky, 1993). It may be that moving away from an educative or instructional style is more uncomfortable for those trainees who struggle with being open to their own emotional experiences. Being truly curious and inquisitive about the client's experiences requires the therapist to tolerate a degree of uncertainty which may be anxiety provoking, particularly under the scrutiny of the training experience. This may further support the notion that difficulties with tolerating such uncertainty may result in therapists engaging in experiential avoidance strategies that undermine their therapeutic effectiveness (Waller and Turner, 2016). Further research would be required to investigate the relationships observed here; however, there is some support for assertions in the established literature that therapist beliefs about emotions can result in an unhelpful didactic or lecturing interpersonal approach during therapy (Leahy, 2015), which is contrary to effective collaboration and guided discovery.

Skills in homework setting were noted to be negatively associated with trainee tendencies for 'Procrastination' as measured by the MEAQ. As suggested by Haarhoff and Kazantzis (2007), trainee therapists may hold unhelpful beliefs about agreeing intersessional work with the client, which means that the process of homework setting provokes uncomfortable feelings. In turn, trainees may procrastinate in session, resulting in their failure to leave enough time to agree homework tasks adequately with the client. Although speculative at this stage, the observations in the data would tentatively support assertions made previously in the literature (Haarhoff and Kazantzis, 2007).

Finally, the MEAQ subscale 'Distress Endurance' was associated with poorer conceptual integration and homework-setting skills. Given that distress endurance indicates an ability to

experience uncomfortable feelings without engaging avoidance strategies, this points to a relationship with observed clinical skills that is inverse to those already considered. Integrating the client's formulation is central to the process of change in CBT, whereby the case conceptualisation should be used explicitly to facilitate a mutual understanding of the problem and provide a rationale for interventions undertaken within, and between, sessions (James *et al.*, 2001). This may be congruent with research suggesting that therapists who are more open to experience, are less likely to conform to the directives of treatment protocols (Peters-Scheffer *et al.*, 2013). Although beyond the scope of the present study to explain, it may be that trainees who find it easier to tolerate discomfort, neglect to use the formulation adequately to guide the treatment process. Similarly, they may set homework tasks without helping the client to consider potential emotional barriers to its completion. After all, 'people should face their fears'.

Implications for CBT training, supervision and practice

This preliminary investigation tentatively supports the notion that therapist experiential avoidance may be important to the process of developing some aspects of CBT competence during training. It may be inferred that CBT training and supervision could focus on helping novice therapists to identify unhelpful emotional schemas and associated avoidance strategies, and how these might interfere with their learning experience, and acquisition and execution of particular key skills. Similarly, this study has highlighted that raising awareness of how seemingly helpful attitudes towards personal distress might also impact upon particular CBT skills may be useful. This could be achieved by formal engagement in an SP/SR process as recommended by Bennett-Levy and colleagues (Bennett-Levy *et al.*, 2001; Bennett-Levy, 2003) and by ensuring that supervision includes an experiential learning element as advocated in the CBT literature (Milne and Reiser, 2017; Milne *et al.*, 2009; Reiser and Milne, 2013). Given that in a post-pandemic world CBT training and supervision can take place remotely in many cases, attention to how experiential learning is achieved (and not avoided) as part of online delivery may be pertinent. As evidenced in the literature, the impact of therapist schemata can continue beyond the training period (Bell *et al.*, 2015; Presley *et al.*, 2017; Scherr *et al.*, 2015) and therefore this further supports the notion that ongoing experiential learning as part of supervision and SP/SR may be beneficial as a continuing professional development objective.

Limitations and implications for further research

Dimensions of trainee therapist experiential avoidance were not observed to be associated with all criteria on the CTSR. Interestingly, differences in observed skills related to interpersonal effectiveness, eliciting client emotions and the application of change methods were not explained by associations with dimensions of experiential avoidance as might have been expected based on previous research. Some of the relationships that were observed have also been treated with caution given individual significance levels, and the number of tests employed in the analyses. It may be that the small sample size employed weakened or obscured any other relationships in the data; indeed, further investigation with a larger sample size is certainly warranted. Such an investigation would helpfully include data collection at different points in the training journey, thereby elucidating whether trainee experiential avoidance changes, and whether this trajectory mirrors that of developing clinical competence. The interaction of different professional backgrounds would be a useful additional factor to incorporate in future research.

Many interpretations of the associations observed in the data have been made here, although these can only be speculative at this stage. Further research is required to understand the complexities of the lived experience of CBT therapists in training, with a focus on elucidating how their own beliefs about emotions impact upon their CBT skills acquisition and execution. Such an exploration could incorporate analysis of observed instances of emotional avoidance as part of

CBT treatment sessions, and as part of clinical supervision. This may be augmented further by exploring the perspectives of CBT supervisors and trainers, and their experience of working with trainees who prefer to avoid emotional discomfort. This is important given that therapist experiential avoidance may also limit the exploration of client emotional experiences, and in some cases collude with unhelpful client emotional schemas which serve to maintain their psychological difficulties. Again, further research would be helpful in understanding the impact of therapist emotional schemas upon clients' experiences and outcomes in therapy, as part of the training journey and beyond. Finally, whilst there are clearly limitations to this exploratory study and the necessity for further investigation, it does serve to remind us of our shared humanity, and the opportunities open to both client *and* therapist for personal development as part of CBT.

Key practice points

- (1) Therapist experiential avoidance may be associated with the development and execution of key CBT skills during CBT training.
- (2) It may be useful for CBT trainers and supervisors to focus on helping trainee therapists to identify unhelpful emotional schemas and how these might interact with their clinical practice.
- (3) It may be beneficial for trainee therapists to be supported to engage in more experiential learning activities as part of challenging these schemas, and developing key CBT skills.
- (4) Trainee therapists may benefit from utilising self-practice and self-reflection in this context as part of their learning journey.

Further reading

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, 29, 203–220.

Leahy, R. L. (2015). *Emotional Schema Therapy*. New York: Guilford Press.

Lombardo, C., Milne, D., & Proctor, R. (2009). Getting to the heart of clinical supervision: a theoretical review of the role of emotions in professional development. *Behavioural and Cognitive Psychotherapy*, 37, 207–219.

Data availability statement. The data that support the findings of this study are available upon reasonable request from the corresponding author (V.P.). The data are not publicly available due to ethical/privacy restrictions related to the research participants and the clients with whom they work.

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References

Anderson, T., Bein, E., Pinnell B. J., & Strupp, H. H. (1999). Linguistic analysis of affective speech in psychotherapy: a case grammar approach. *Psychotherapy Research*, 9, 88–99. <https://doi.org/10.1080/10503309912331332611>

- Arch, J., Eifert, G., Davies, C., Vilardaga, J., Rose, R., & Craske, M. (2012). Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology, 80*, 750–765. doi: [10.1037/a0028310](https://doi.org/10.1037/a0028310)
- Baker, R., Owens, M., Thomas, S., Whittlesea, A., Abbey, G., Gower, P., Tosunlar, L., Corrigan, E. & Thomas, P. W. (2012). Does CBT facilitate emotional processing? *Behavioural and Cognitive Psychotherapy, 40*, 19–37. doi: [10.1017/S1352465810000895](https://doi.org/10.1017/S1352465810000895)
- Barlow, D. (2011). *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders Therapist Guide (Treatments that Work)*. Oxford: Oxford University Press.
- Beck, A. (1989). *Cognitive Therapy and the Emotional Disorders*. London: Penguin.
- Bell, T., Mackie, L., & Bennett-Levy, J. (2015). ‘Venturing towards the dark side’: the use of imagery interventions by recently qualified cognitive-behavioural therapists. *Clinical Psychology and Psychotherapy, 22*, 591–603. <https://doi.org/10.1002/cpp.1920>
- Bennett-Levy, J. (2003). Mechanisms of change in cognitive therapy: the case of automatic thought records and behavioural experiments. *Behavioural and Cognitive Psychotherapy, 31*, 261–277. doi: [10.1017/S1352465803003035](https://doi.org/10.1017/S1352465803003035)
- Bennett-Levy, J. (2006). Therapist skills: a cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy, 34*, 57–78. doi: [10.1017/S1352465805002420](https://doi.org/10.1017/S1352465805002420)
- Bennett-Levy, J., Lee, N., Travers, K., Pohlman, S., & Hamernik, E. (2003). Cognitive therapy from the inside: enhancing therapist skills through practising what we preach. *Behavioural and Cognitive Psychotherapy, 31*, 143–158. doi: [10.1017/S1352465803002029](https://doi.org/10.1017/S1352465803002029)
- Bennett-Levy, J., McManus, F., Westling, B., & Fennell, M. (2009). Acquiring and refining CBT skills and competencies: which training methods are perceived to be most effective? *Behavioural and Cognitive Psychotherapy, 37*, 571–583. doi: [10.1017/S1352465809990270](https://doi.org/10.1017/S1352465809990270)
- Bennett-Levy, J., & Thwaites, R. (2007). Self and self-reflection in the therapeutic relationship. In P. Gilbert & R. L. Leahy (eds), *The Therapeutic Relationship in the Cognitive Behavioral Psychotherapies* (pp. 255–281). Routledge.
- Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy, 29*, 203–220. doi: [10.1017/S1352465801002077](https://doi.org/10.1017/S1352465801002077)
- Bennett-Levy, J., Westbrook, D., Fennell, M., Cooper, M., Rouf, K. & Hackman, A. (2004). Behavioural experiments: historical and conceptual underpinnings. In J. Bennet-Levy, G. Butler, M. Fennell, A. Hackman, M. Mueller & D. Westbrook (eds), *Oxford Guide to Behavioural Experiments in Cognitive Therapy* (pp. 1–20). Oxford: Oxford University Press.
- Blackburn, I., James, I., Milne, D., Baker, C., Standart, S., Garland, A., & Reichelt, F. (2001). The revised Cognitive Therapy Scale (CTS-R): psychometric properties. *Behavioural and Cognitive Psychotherapy, 29*, 431–446. doi: [10.1017/S1352465801004040](https://doi.org/10.1017/S1352465801004040)
- Blume-Marcovici, A., Stolberg, R., & Khademi, M. (2013). Do therapists cry in therapy? The role of experience and other factors in therapists’ tears. *Psychotherapy, 50*, 224–234. doi: [10.1037/a0031384](https://doi.org/10.1037/a0031384)
- Carlucci, L., Saggino, A., & Balsamo, M. (2021). On the efficacy of the unified protocol for transdiagnostic treatment of emotional disorders: a systematic review and meta-analysis. *Clinical Psychology Review, 87*, 101999. <https://doi.org/10.1016/j.cpr.2021.101999>
- Chawla, N., & Ostafin, B. (2007). Experiential avoidance as a functional dimensional approach to psychopathology: an empirical review. *Journal of Clinical Psychology, 4*, 871–890. <https://doi.org/10.1002/jclp.20400>
- Eustis, E., Cardona, N., Nauphal, M., Sauer-Zavala, S., Rosellini, A., Farchione, T., & Barlow, D. (2019). Experiential avoidance as a mechanism of change across cognitive-behavioral therapy in a sample of participants with heterogeneous anxiety disorders. *Cognitive Therapy and Research, 44*, 275–286. <https://doi.org/10.1007/s10608-019-10063-6>
- Gámez, W., Chmielewski, M., Kotov, R., Ruggero, C., & Watson, D. (2011). Development of a measure of experiential avoidance: the Multidimensional Experiential Avoidance Questionnaire. *Psychological Assessment, 23*, 692–713. <https://doi.org/10.1037/a0023242>
- Gross, J., & Levenson, R. (1997). Hiding feelings. *Journal of Abnormal Psychology, 106*, 95–103. <https://doi.org/10.1037/0021-843X.106.1.95>
- Haarhoff, B. A. (2006). The importance of identifying therapist schema in cognitive therapy training and supervision. *New Zealand Journal of Psychology, 35*, 126–131.
- Haarhoff, B., Gibson, K., & Flett, R. (2011). Improving the quality of cognitive behaviour therapy case conceptualization: the role of self-practice/self-reflection. *Behavioural and Cognitive Psychotherapy, 39*, 323–339. doi: [10.1017/S1352465810000871](https://doi.org/10.1017/S1352465810000871)
- Haarhoff, B., & Kazantzis, N. (2007). How to supervise the use of homework in cognitive behavior therapy: the role of trainee therapist beliefs. *Cognitive and Behavioral Practice, 14*, 325–332. <https://doi.org/10.1016/j.cbpra.2006.08.004>
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: a functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152–1168. <https://doi.org/10.1037/0022-006X.64.6.1152>

- James, I. A., Blackburn, I. M., & Reichelt, F. K. (2001). Manual of the revised cognitive therapy scale. Unpublished manuscript, Newcastle Cognitive and Behavioural Therapies Centre, Newcastle, UK. Available at: <https://www.ed.ac.uk/files/atoms/files/ctsrmanual.pdf>
- Kolb, D. A. (1984). *Experiential Learning*. Prentice-Hill.
- Laposa, J., Collimore, K., Hawley, L., & Rector, N. (2015). Distress tolerance in OCD and anxiety disorders, and its relationship with anxiety sensitivity and intolerance of uncertainty. *Journal of Anxiety Disorders*, 33, 8–14. <https://doi.org/10.1016/j.janxdis.2015.04.003>
- Leahy, R. L. (2001). *Overcoming Resistance in Cognitive Therapy*. New York: Guilford Press.
- Leahy, R. L. (2015). *Emotional Schema Therapy*. New York: Guilford Press.
- Leahy, R. L. (2016). Emotional schema therapy: a meta-experiential model. *Australian Psychologist*, 51, 82–88. <https://doi.org/10.1111/ap.12142>
- Lombardo, C., Milne, D., & Proctor, R. (2009). Getting to the heart of clinical supervision: a theoretical review of the role of emotions in professional development. *Behavioural and Cognitive Psychotherapy*, 37, 207–219. doi: [10.1017/S135246580900513X](https://doi.org/10.1017/S135246580900513X)
- Macatee, R., Albanese, B., Allan, N., Schmidt, N., & Coughle, J. (2016). Distress intolerance as a moderator of the relationship between daily stressors and affective symptoms: tests of incremental and prospective relationships. *Journal of Affective Disorders*, 206, 125–132. <https://doi.org/10.1016/j.jad.2016.07.035>
- Macatee, R., Capron, D., Guthrie, W., Schmidt, N., & Coughle, J. (2015). Distress tolerance and pathological worry: tests of incremental and prospective relationships. *Behavior Therapy*, 46, 449–462. <https://doi.org/10.1016/j.beth.2015.03.003>
- Mackay, H. C., Barkham, M., Stiles, W. B., & Goldfried, M. R. (2002). Patterns of client emotion in helpful sessions of cognitive-behavioral and psychodynamic-interpersonal therapy. *Journal of Counseling Psychology*, 49, 376–380. <https://doi.org/10.1037/0022-0167.49.3.376>
- McManus, F., Van Doorn, K., & Yiend, J. (2011). Examining the effects of thought records and behavioral experiments in instigating belief change. *Journal of Behavior Therapy and Experimental Psychiatry*, 43, 540–547. <https://doi.org/10.1016/j.jbtep.2011.07.003>
- Meyer, J., Farrell, N., Kemp, J., Blakey, S., & Deacon, B. (2014). Why do clinicians exclude anxious clients from exposure therapy? *Behaviour Research and Therapy*, 54, 49–53. <https://doi.org/10.1016/j.brat.2014.01.004>
- Michel, N. M., Rowa, K., Young, L., & McCabe, R. E. (2016). Emotional distress tolerance across anxiety disorders. *Journal of Anxiety Disorders*, 40, 94–103. <https://doi.org/10.1016/j.janxdis.2016.04.009>
- Milne, D., Leck, C., & Choudhri, N. (2009). Collusion in clinical supervision: literature review and case study in self-reflection. *the Cognitive Behaviour Therapist*, 2, 106–114. <https://doi.org/10.1017/S1754470X0900018X>
- Milne, D., & Reiser, R. P. (2017). *A Manual for Evidence-Based CBT Supervision*. John Wiley & Sons.
- Niles, A., Burklund, L., Arch, J., Lieberman, M., Saxbe, D., & Craske, M. (2014). Cognitive mediators of treatment for social anxiety disorder: comparing acceptance and commitment therapy and cognitive-behavioral therapy. *Behavior Therapy*, 45, 664–677. doi: [10.1016/j.beth.2014.04.006](https://doi.org/10.1016/j.beth.2014.04.006)
- Padesky, C. A. (1993). *Socratic Questioning: Changing Minds or Guiding Discovery?* Invited keynote address presented at the 1993 European Congress of Behavioural and Cognitive Therapies, London.
- Peters-Scheffer, N., Didden, H., Korzilius, H., & Sturmey, P. (2013). Therapist characteristics predict Discrete Trial Teaching procedural fidelity. *Intellectual and Developmental Disabilities*, 51, 263–272. <https://doi.org/10.1352/1934-9556-51.4.263>
- Power, M. (2010). Too little emotion. In M. Power (ed), *Emotion-Focused Cognitive Therapy* (pp. 103–124). John Wiley & Sons.
- Presley, V. L., Jones, C. A., & Newton, E. K. (2017). Are perfectionist therapists perfect? The relationship between therapist perfectionism and client outcomes in cognitive behavioural therapy. *Behavioural and Cognitive Psychotherapy*, 45, 225–237. doi: [10.1017/S1352465817000054](https://doi.org/10.1017/S1352465817000054)
- Reiser, R., & Milne, D. (2013). Cognitive behavioral therapy supervision in a university-based training clinic: a case study in bridging the gap between rigor and relevance. *Journal of Cognitive Psychotherapy*, 27, 30–41. <http://doi.org/10.1891/0889-8391.27.1.30>
- Scherr, S., Herbert, J., & Forman, E. (2015). The role of therapist experiential avoidance in predicting therapist preference for exposure treatment for OCD. *Journal of Contextual Behavioral Science*, 4, 21–29. <https://doi.org/10.1016/j.jcbs.2014.12.002>
- Shallcross, A., Troy, A., Boland, M., & Mauss, I. (2010). Let it be: accepting negative emotional experiences predicts decreased negative affect and depressive symptoms. *Behaviour Research and Therapy*, 48, 921–929. <https://doi.org/10.1016/j.brat.2010.05.025>
- Stanton, A. L., Danoff-Burg, S., Cameron, C. L., Bishop, M., Collins, C. A., Kirk, S. B., Sworowski, L. A., & Twillman, R. (2000). Emotionally expressive coping predicts psychological and physical adjustment to breast cancer. *Journal of Consulting and Clinical Psychology*, 68, 875–882. <https://doi.org/10.1037/0022-006X.68.5.875>
- Teasdale, J. D. (1997). The relationship between cognition and emotion: the mind in place in mood disorders. In D. M. Clark & C. G. Fairburn (eds), *The Science and Practice of Cognitive Behaviour Therapy* (pp. 67–93). Oxford University Press.

- Waller, G., & Turner, H.** (2016). Therapist drift redux: why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy*, 77, 129–137. <http://doi.org/10.1016/j.brat.2015.12.005>
- Wilamowska, Z., Thompson-Hollands, J., Fairholme, C., Ellard, K., Farchione, T., & Barlow, D.** (2010). Conceptual background, development, and preliminary data from the unified protocol for transdiagnostic treatment of emotional disorders. *Depression and Anxiety*, 27, 882–890. doi: [10.1002/da.20735](https://doi.org/10.1002/da.20735)
- Young, J. E., Klosko, J. S., & Weishaar, M. E.** (2003) *Schema Therapy: A Practitioner's Guide*. New York: Guilford Press.

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